MATERNAL AND CHILD HEALTH PROGRAM including the Children and Youth with Special Health Care Needs

Program Boundary Statement

Program Quality Criteria

Program Objectives

2007 Program Boundary Statement
Maternal and Child Health Including
Children and Youth with Special Health Care Needs

For each performance-based contract program, the Division of Public Health has identified a Boundary Statement. The Boundary Statement sets the parameters of the program within which the Local Public Health Department (LPHD), Tribe or agency will need to set its objectives. The boundaries are intentionally as broad as federal and state law permit to provide maximum flexibility. However, if there are objectives or program directions that the program is not willing to consider or specific programmatic parameters, those are included in the Boundary Statement.

LPHDs, Tribes and agencies are encouraged to leverage resources across categorical funding to achieve common program goals. The Maternal and Child Health (MCH) Program aligns well with the boundaries of the Childhood Lead Poisoning Prevention, Immunization, Preparedness, Prevention, Reproductive Health, and Tobacco Prevention and Control programs.

Program Boundary Statement:

Long-term Program Goals:
The Title V MCH/Children and Youth with Special Health Care Needs (CYSHCN) Services Block Grant has, as its general purpose, the improvement of the health of all mothers and children in the nation consistent with the applicable health status goals and national health objectives established by the Secretary under the Public Health Service Act for the Year 2010.

The MCH Formula Grants to States are to enable each State: (per Federal language)

- To provide and assure mothers and children (especially those with low income or limited availability to services) access to quality MCH services;
- To reduce infant mortality and incidence of preventable diseases and handicapping conditions among children; to reduce the need for inpatient and long-term health services; to increase the number of children appropriately immunized against disease and the number of low income children receiving health assessments and follow-up diagnostic and treatment services; and otherwise to promote the health of mothers and infants by providing prenatal, delivery, and postpartum care for low income, at-risk pregnant women, and to promote the health of children by providing preventive and primary care services for low income children;
- To provide and promote family-centered, community-based, coordinated care (including care coordination services) for children with special health care needs and to facilitate the development of community-based, systems of service for such children and their families.

States are required to use their Federal MCH Block Grant funds in the following way:

- At least 30% of funds received for preventive and primary care services for children; and
- At least 30% of funds received for services for children with special health care needs.

Annual Program Goals:

The MCH/CYSHCN program is intended to increase healthy birth outcomes, and promote optimal growth and development for children and their families.

National Performance Measures

- The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.
- The percent of children with special health care needs age 0 to 18 years whose families' partner in decision-making at all levels and are satisfied with the services they receive.
- The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home.
- The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need.
- Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily.
- The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.
- Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.
- The rate of birth (per 1,000) for teenagers aged 15 through 17 years.
- Percent of third grade children who have received protective sealants on at least one permanent molar tooth.
- The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.
- The percent of mothers who breastfeed their infants at 6 months of age.
- Percentage of newborns that have been screened for hearing before hospital discharge.
- Percent of children without health insurance.
- Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.
- Percentage of women who smoke in the last three months of pregnancy.
- The rate (per 100,000) of suicide deaths among youths aged 15 through 19.
- Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.
- Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

State Performance Measures

- Percent of eligible women enrolled in the Wisconsin Medicaid Family Planning Waiver during the year.
- Percent of Medicaid and BadgerCare recipients, ages 3-20, who received any dental service during the reporting year.
- Percent of children, ages 6 months-5 years, who have age-appropriate social and emotional developmental levels.

- Rate per 1,000 of substantiated reports of child maltreatment to Wisconsin children, ages 0 - 17, during the year.
- Percent of children who receive coordinated, ongoing comprehensive care within a medical home.
- Percent of children less than 12 years of age who receive one physical exam a year.
- Percent of women who use tobacco during pregnancy.
- Percent of children, ages 2-4, who are obese or overweight.
- Ratio of the black infant mortality rate to the white infant mortality rate.
- Death rate per 100,000 among youth, ages 15-19, due to motor vehicle crashes.

Target Populations:

The populations served under this Title V federal funding include women of childbearing age, pregnant women, and children birth to 21 years old, including children with special health care needs, and their families. Agencies are encouraged to focus on racial and ethnic disparities and healthy birth outcomes as appropriate.

References:

Federal Regulations/Guidelines:

Title V of the Social Security Act Maternal and Child Health Services Block Grant - Section 501-510.

State of Wisconsin Statutes:

WI Statute ch. 253 - Maternal and Child Health
- s.253.06 - State supplemental food program for women, infants, and children
- s.253.07 - Family planning (Wisconsin Administrative Code Chapter HFS 151 describes family planning fund allocations).
- s.253.08 - Pregnancy counseling services
- s.253.085 - Outreach to low-income pregnant women
- s.253.09 - Abortion refused; no liability; no discrimination
- s.253.10 - Voluntary and informed consent for abortions
- s.253.11 - Infant blindness
- s.253.115 - Newborn hearing screening
- s.253.12 - Birth and developmental outcome monitoring program
- s.253.13 - Tests for congenital disorders
- s.253.14 - Sudden infant death syndrome

Program Policies:

Optimal or Best Practice Guidance:

The Contractee must assure quality by utilizing one or more of the following documents for guidance in the organization and delivery of services:

- Wisconsin Medicaid Prenatal Care Coordination Services Handbook and related Medicaid Updates
- Family Planning Reproductive Health Standards of Practice

- Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents, Second Edition
- Caring for Our Children: National Health and Safety Performance Standards Guidelines for Out-of-Home Child Care Programs: Second Edition, 2002
- Bright Futures in Practice: Oral Health
- Bright Futures in Practice: Physical Activity
- Bright Futures in Practice: Nutrition, Second Edition
- Bright Futures in Practice: Mental Health

The intent of the Title V MCH/CYSCHN Services Block Grant is to address the health needs of mothers, infants, children, adolescents, and families in Wisconsin. We are required by federal legislation to conduct a five year needs assessment to determine Wisconsin's program priorities for maternal and child health. Based on results of the needs assessment, the Wisconsin MCH/CYSHCN Program has established template objectives reflecting some of these priorities as well as promoting measurable outcome achievements. However, it is important to note that these are not required objectives.

Unacceptable Proposals:

When using Title V MCH/CYSCHN Service Block Grant funds, the following activities are non-allowable:

- Conducting Medicaid outreach
- Providing and paying for services for people who are eligible for Medical Assistance (MA) and the service is covered by MA or the Birth to 3 Program. Title V is the payer of last resort.
- Conducting health fairs with no demonstrated knowledge or behavior change for the family or client
- Providing dental <u>treatment</u> services. Primary prevention dental services such as sealant application are acceptable.
- Objectives relating solely to the payment of FTEs to conduct MCH activities with no product stated.
- Reimbursement solely for data entry (e.g., SPHERE or Wisconsin Immunization Registry).
- Objectives only for the <u>referral</u> of patients to dental providers.
- Providing perinatal care coordination services to a designated number of women without reporting key perinatal outcomes. (see perinatal care coordination template objective)
- Educational objectives that focus <u>only</u> on increasing knowledge (a skill demonstration or behavior change component must be included).

Relationship to State Health Plan: *Healthiest Wisconsin 2010:*

MCH Problem/Need *	Healthiest Wisconsin 2010 Priority
1. Access to health care for children	Access to primary & preventive health services
2. Health insurance coverage	Access to primary & preventive health services
3. Child abuse and neglect	Intentional & unintentional injury and violence
4. Infant mortality	Access to primary & preventive health services Social & economic factors that influence health
5. Low birth weight	Access to primary & preventive health services Tobacco use and exposure
6. First trimester prenatal care	Access to primary & preventive health services
7. Teen births	High risk sexual behavior
8. Women's mental health/depression	Mental health and mental disorders
9. Smoking among pregnant women	Tobacco use and exposure
10. Adolescent mental health	Mental health & mental disorders
11. Contraceptive services	High risk sexual behavior
12. Unintended pregnancy	High risk sexual behavior
13. Overweight and at risk for overweight	Overweight, obesity & lack of physical activity
14. Dental caries	Access to primary & preventive health services
15. Infant and early childhood mental health	Access to primary & preventive health services Mental health & mental disorders
16. Unintentional childhood injuries	Intentional & unintentional injury and violence
17. Tobacco use among youth	Tobacco use & exposure
18. Children with special health care needs have adequate insurance	Access to primary & preventive health services
19. Intentional childhood injuries	Intentional & unintentional injury and violence
20. Children with special health care needs receive care within a medical home	Access to primary & preventive health services

***** MCH Problems/Needs not listed in priority order

2007 Program Quality Criteria
Maternal and Child Health Including
Children and Youth with Special Health Care Needs

Generally high program quality criteria for the delivery of quality and cost-effective administration of health care programs have been, and will continue to be, required in each public health program to be operated under the terms of this contract. Contractees should indicate the manner in which they will assure each criterion is met for this program. Those criteria include:

Assessment and surveillance of public health to identify community needs and to support systematic, competent program planning and sound policy development with activities focused at both the individual and community levels.

A. Contractees must include a maternal and child health needs assessment at least every five years in their community needs assessment process, as required by Title V of the Social Security Act.

Delivery of public health services to citizens by qualified health professionals in a manner that is family centered, culturally competent, and consistent with the best practices; and delivery of public health programs for communities for the improvement of health status.

A. Contractees must assure that maternal and child health services are delivered and supervised by qualified staff as required by the activity or service being delivered.

B. Contractees must designate a staff person as the maternal and child health contact to receive, disseminate, and respond to policy and program information provided by the State.

C. Contractees must designate a staff person as the children and youth with special health care needs contact to receive and disseminate policy and program information provided by the State and Regional CYSHCN Centers.

D. The Contractee must assure quality by utilizing one or more of the following documents as guidance in the organization and delivery of services.
    - Wisconsin Medicaid Prenatal Care Coordination Services Handbook and related Medicaid Updates
    - Family Planning Reproductive Health Standards of Practice
    - Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents, Second Edition
    - Caring for Our Children: National Health and Safety Performance Standards Guidelines for Out-of-Home Child Care Programs: Second Edition, 2002
    - Bright Futures in Practice: Oral Health
    - Bright Futures in Practice: Physical Activity
    - Bright Futures in Practice: Nutrition, Second Edition

- Bright Futures in Practice: Mental Health

All programs will be evaluated based on these best practice guidelines. If a local health department (LHD) wants to use an alternate, but comparable document, the State of Wisconsin Maternal and Child Health Program must approve it.

E. Contractees must integrate the MCH Five Guiding Principles in MCH programs, services and systems.

Record keeping for individually focused services that assure documentation and tracking of client health care needs, response to known health care problems on a timely basis, and confidentiality of client information.

A. Contractees must assure that all general health care records are kept confidential as required by s. 146.82, Wis. Stats.

Information, education, and outreach programs intended to address known health risks in the general and certain target populations to encourage appropriate decision making by those at risk and to affect policy and environmental changes at the community level.

A. Contractees must assure effective outreach strategies to high-risk women of childbearing age, pregnant women, and children birth to 21 years old, including children and youth with special health care needs and their families in the maternal and child health population.

B. All materials for public distribution developed by a Contractee with Title V MCH Block Grant funds must identify the funding source on the publication as follows: "Funded in part by the MCH Title V Services Block Grant, Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services."

Coordination with related programs to assure that identified public health needs is addressed in a comprehensive, cost-effective manner across programs and throughout the community.

A. Contractees must have a mechanism in place to assure coordination with the Regional CYSHCN Centers.

B. Contractees must coordinate maternal and child health programs with other community health programs.

A referral network sufficient to assure the timely provision of services to address identified client health care needs.

A. LHDs that provide maternal and child health prevention and intervention services must have a referral network. Referral networks may include: healthcare providers including mental health and oral health, Regional CYSHCN Centers, child care centers, WIC, human or social services, schools, Birth to 3 programs, and other relevant services.

Provision of guidance to staff through program and policy manuals and other means sufficient to assure quality client care and cost-effective program administration.

Financial management practices sufficient to assure accurate eligibility determination, pursuit of third-party insurance and Medical Assistance coverage of services provided, prompt and accurate billing and payment for services provided and purchased, accurate expenditure reporting, and appropriate use of state and federal funds.

A. Contractees must seek other available funding sources, as Title V MCH Block Grant is payer of last resort.

B. Contractees must bill the Wisconsin Medical Assistance Program for all covered services provided to eligible recipients.

C. Contractees must provide 75% match ($0.75 local contribution for every $1.00 federal) for all Title V MCH Block Grant funds.

Data collection, analysis, and reporting to assure program outcome goals are met or to identify program management problems that need to be addressed.

A. Contractees must collect and analyze data on all public health activities and interventions provided.

B. Contractees must report using SPHERE (Secure Public Health Electronic Record Environment).

C. Contractees will comply with year-end program reporting requirements set by the State of Wisconsin MCH Program including documentation of 75% match ($0.75 local contribution for every $1.00 federal).

2007 MCH Program Template Objectives

Infant Health Care Coordination

Objective Statement: By December 31, 2007, **(insert #)** at-risk infants will receive health care coordination services from **(insert name of local health department)** that focus on primary health exams, immunizations, and developmental screening according to American Academy of Pediatrics recommendations.

Deliverable: A report to document the number of at-risk infants who received health care coordination services from **(insert name of local health department)** including 1) the number of visits, 2) the number or percent of primary health examinations and immunizations received according to the American Academy of Pediatrics recommended schedule, and 3) the number and results of ASQ and ASQ:SE screenings.

Context: This program is targeted to infants and families not enrolled in the Wisconsin Medicaid Program. All local public health departments receive birth certificate records transmitted daily from State Vital Records. **(Insert name of local health department)** periodically screens these records for case finding of at-risk infants and their families using one or more of the following criteria: **(Insert at-risk criteria selected from the following factors: teenage mother, late prenatal care, less than 7 prenatal visits, prenatal care commenced after 28 weeks gestation, less than 13 months since last delivery, congenital anomalies, low birth weight, admitted to neonatal intensive care unit, small for gestational age, infant referred from the Wisconsin Birth Defect Registry, and/or other factors based on local needs assessment.)** To provide essential services to infants referred from the Wisconsin Birth Defects Registry and their families, it is expected that there be a cooperative relationship developed between the CYSHCN Regional Center and local health department. Care coordination will be provided as defined and described in the Minnesota Model of Public Health Interventions Manual, Case Management intervention, Individual/Family Practice level," page 93. Well child exams are according to the periodicity recommended by the American Academy of Pediatrics and include necessary primary health care services, education and anticipatory guidance to maintain optimal health status, as reflected in "Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents." The ASQ and ASQ: SE tools are recommended for use in programs periodically screening beginning at 6 months of age for infant developmental achievements and social-emotional behavioral competence.

Input Activities: Provide the number of expected visits your program intends to provide to each enrolled infant and family until their first birthday.

Data Source for Measurement: SPHERE Individual/Household report to include the MCH required demographic data and data from the following screens: Infant Assessment and Developmental Assessment: ASQ and ASQ: SE.

For Your Information: This objective is intended to provide services to infants and families that are comprehensive and frequent with multiple visits occurring throughout the child's first year of life.

2007 MCH Program Template Objectives
ASQ: Social-Emotional Screening

Objective Statement: By December 31, 2007, **(insert number)** children ages 6 months to 5 years will receive social-emotional developmental assessments from **(insert name)** Health Department.

Deliverable: A report to document the number of children ages 6 months to 5 years who received social-emotional developmental assessments from **(insert name)** Health Department.

Context: Ages and Stages Questionnaire: Social Emotional (ASQ: SE) assessment is the required screening tool to be used for this objective. This questionnaire, which assesses children's social-emotional development at 6, 12, 18, 24, 30, 36, 48, and 60 months, is available from Brookes Publishing at http://www.brookes publishing.com/store/books/squires-asqse/index.htm.

Data Source for Measurement: SPHERE Individual/Household Report to include MCH Required Demographic Data and data from the following screen: Developmental Assessment ASQ: SE.

For Your Information: Training from University of Wisconsin-Extension is available to assure use of ASQ: SE tool as intended. For more information about scheduled trainings in 2007, check this Web site: http://www.uwex.edu/ces/flp/homevisit/training/index.cfm.

2007 MCH Program Template Objectives
Perinatal Care Coordination

Objective Statement: By December 31, 2007, **(insert number)** women will receive comprehensive perinatal care coordination services from **(insert name)** Health Department that includes a focus on tobacco use and exposure, depression, breastfeeding, safe infant sleep practices and postpartum contraception.

Deliverable: A report to document the number of women who received comprehensive perinatal care coordination services from **(insert name)** Health Department; and the number of those women who 1) decreased exposure to tobacco smoke, 2) received screening, referral and follow-up services for perinatal depression, 3) initiated and continued to breastfeed for one month, 4) demonstrated knowledge of safe infant sleep practices, and 5) received contraception services prior to delivery.

Context: Perinatal care coordination services include outreach, assessment, care plan development, ongoing care coordination, health education and nutrition counseling and are available during pregnancy through 60 days following delivery for women who are not eligible for the Medicaid Prenatal Care Coordination (PNCC) benefit. Perinatal care coordination services are comprehensive, and follow the Guidelines and Performance Measurements for PNCC. (See Appendix 7 of the Medicaid PNCC Handbook at www.dhfs.state.wi.us/Medicaid2/handbooks/pncc/index.htm.) Documentation of comprehensive services includes completion of all fields in the SPHERE screens for Prenatal Assessment, Postpartum Assessment, Referral and Follow-up/Results, and Health Teaching Topics and Results. Comprehensive perinatal care coordination services will include a focus on the following evidence-based and promising practices: 1) Smoking cessation services will be provided for pregnant women based on the First Breath Program of the Wisconsin Women's Health Foundation focusing on the 5A's: Ask, Advise, Assess, Assist, and Arrange. Smoking by household members will also be addressed. 2) Perinatal depression screening will be provided at the first prenatal visit, during the 3rd trimester, and in the postpartum period using basic screening questions (included on the PNCC Pregnancy Questionnaire) and a standardized screening tool for follow-up assessments (Edinburough, CES-D, or other standardized tool). See the WAPC position statement on Perinatal Depression available at www.perinatalweb.org. 3) Breastfeeding promotion and support will be provided during pregnancy and in the early postpartum period. 4) Education on safe infant sleep practices will include the American Academy of Pediatric Guidelines. See recommendations at http://aappolicy.aappublications.org/cgi/content/full/pediatrics;116/5/1245. 5) PNCC clients will have postpartum contraception on hand prior to delivery and have plans in place for continuing supplies and services following delivery through their medical provider, local family planning clinic or the Emergency Contraception/Family Planning Waiver Response Line.

Data Source for Measurement: SPHERE Individual/Household Report to include the MCH Required Demographic Data and data from the following screens: Prenatal Assessment, Postpartum Assessment, Referral and Follow-up/Results, and Health Teaching Topics and Results.

2007 MCH Program Template Objectives
Perinatal Systems Building

Objective Statement: By December 31, 2007, the **(insert name of coalition, collaborative or partnership)** will implement **(insert number)** strategies to reduce disparities in perinatal outcomes for **(insert population focus or name of jurisdiction)**.

Deliverable: A report to document the **(insert name of coalition, collaborative or partnership)** and the number of strategies it implemented to reduce disparities in perinatal outcomes.

Context: Collaboration is a key component of this objective to promote perinatal system-building activities within the community. Potential partners may include consumers, hospital administrators, medical providers who serve pregnant women and children, WIC staff, lactation educators and consultants, home visitors, and representatives from the Wisconsin Association for Perinatal Care, Infant Death Center of Wisconsin, March of Dimes, Wisconsin Women's Health Foundation, Center for Tobacco Research and Intervention, domestic violence coalitions, social service departments, housing assistance programs, faith-based organizations, women's organizations, and other community-based organizations. This objective supports evidence-based strategies or promising practices to reduce disparities in perinatal outcomes. Strategies that may be implemented through this objective include: 1) Establish or form a partnership with a local perinatal coalition. 2) Identify local needs and develop a community plan to build systems to reduce disparities in perinatal outcomes. 3) Implement strategies identified in the community plan. 4) Collaborate with regional Healthy Babies Action Teams to implement strategies at the local level. 5) Establish policies for pregnant and postpartum women to receive first priority for oral health and/or mental health services from local providers. 6) Establish fatherhood initiative programs such as incentives to promote fathers to attend prenatal care appointments, fatherhood parenting classes, or smoking cessation support. 7) Establish a Cribs for Kids program to spread a uniform safe infant sleep message and provide a portable crib to families in need. (See www.cribsforkids.org) 8) Develop a plan with medical providers who serve pregnant women, pediatricians, WIC staff, prenatal care coordinators, home visitors and others to assure that all women are screened for depression using a standardized tool during the first and third trimesters of pregnancy, around 6 weeks postpartum, and one other time in the postpartum year. (See www.perinatalweb.org)

Input Activities: Include a brief description of the strategies chosen and the plan for implementation.

Data Source for Measurement: SPHERE System Report to include data from the following screens: System Activity (all appropriate fields including the strategies documented in the Results/Outcomes field) and Intervention: Coalition Building (no detail screen), Community Organizing (no detail screen), or Collaboration (no detail screen).

2007 MCH Program Template Objectives
Child Passenger Seat

Objective Statement: By December 31, 2007, **(insert number)** children ages birth through **(insert number)** years from **(insert name of jurisdiction)** will be properly positioned in a child car passenger seat system as demonstrated by their parent or caregiver.

Deliverable: A report to document the number of children ages birth through **(insert number)** years from **(insert name of jurisdiction)** who were properly positioned in a child car passenger seat system by their parents or other caregivers.

Context: This objective is for local health department programs that provide designated individual assessment, installation and instruction services to families with one or more children in the selected age group.

Data Source for Measurement: SPHERE Individual/Household Report to include MCH Required Demographic Data and data from the following screen: Child Passenger Safety Seat.

For Your Information: Child passenger seat programs are expected to follow the National Highway Traffic Safety Administration recommendations (see www.nhtsa.dot.gov) and employ certified staff in their programs. If using the SafeKids form, the agency must also collect and report additional MCH Program required data; that is, the birth date and race of the child and health care coverage information. To count toward this objective, a pregnant woman instructed on child passenger safety seat installation must return with the baby after the baby is born to document proper positioning.

2007 MCH Program Template Objectives
CYSHCN Referral, Follow-up

Objective Statement: By December 31, 2007, **(insert number)** children and youth with special health care needs and their families will receive referral and follow-up from **(insert name)** Health Department.

Deliverable: A report to document the number of children and youth with special health care needs and their families who received referral and follow-up from **(insert name)** Health Department.

Context: The required data elements for the Children and Youth with Special Health Care Needs (CYSHCN) Program are contained in the CYSHCN Intake Form, which has the required data elements highlighted.

Data Source for Measurement: SPHERE Individual/Household Report to include MCH Required Demographic Data, required CYSHCN data elements from the CYSHCN Intake Form and data from the following screens: Health Care Utilization, CYSHCN Transition (required for ages 14 to 21 years), and Referral and Follow-up/Results.

For Your Information: For a copy of the CYSHCN Intake Form, send your request to Amy Whitehead by e-mail at whitead@dhfs.state.wi.us or call (608) 267-3861.

2007 MCH Program Template Objectives
CYSHCN Case Management

Objective Statement: By December 31, 2007, **(insert number)** children and youth with special health care needs and their families will receive case management from **(insert name)** Health Department.

Deliverable: A report to document the number of children and youth with special health care needs and their families who received case management from **(insert name)** Health Department.

Context: The required data elements for the Children and Youth with Special Health Care Needs (CYSHCN) Program are contained in the CYSHCN Intake Form, which has the required data elements highlighted.

Data Source for Measurement: SPHERE Individual/Household Report to include the MCH Required Demographic Data, required CYSHCN data elements from the CYSHCN Intake Form and data from the following screens: Health Care Utilization, CYSHCN Transition (required for ages 14 to 21 years), CYSHCN Care Coordination/Assessment, CYSHCN Care Plan (no detail screen), and CYSHCN Ongoing Monitoring (no detail screen).

For Your Information: For a copy of the CYSHCN Intake Form, send your request to Amy Whitehead by e-mail at whitead@dhfs.state.wi.us or call (608) 267-3861.

2007 MCH Program Template Objectives
CYSHCN Systems

Objective Statement: By December 31, 2007, **(insert number)** strategies for local infrastructure building that support and promote the National Performance Outcome for Medical Home and will be implemented by the **(insert name)** Health Department.

Deliverable: A report to include a description of the infrastructure changes and outcomes that occurred as a result of the implementation of the strategies implemented by the **(insert name)** Health Department.

Context: Many children and youth with special health care needs fall through the cracks through the lack of a Medical Home. The federal Title V Maternal Child Health Bureau (MCHB) has identified six National Performance Outcomes (NPOs) that serve as the framework for the Wisconsin CYSHCN Program. Wisconsin was selected as a leadership state by MCHB for its work in Medical Home and efforts to further spread the Medical Home approach are underway. Local public health departments are in a position to facilitate local capacity building to address the second outcome: that is, all children and youth with special health care needs will receive coordinated ongoing comprehensive care within a medical home. Strategies that may be implemented through this objective include: 1) Engage parents as partners in decision making through recruiting and sustaining their participation in a Medical Home pilot. 2) Assure developmental screening through local public health links to primary care. 3) Assist existing entities (e.g., WIC clinic or schools) to establish methods for securing health insurance or increased coverage for the uninsured or partially insured children and youth with special health care needs through work with the Medical Home. 4) Increase the number of community providers who are trained to used a validated developmental screening tool (e.g., Ages and Stages) consistent with the American Academy of Pediatrics Developmental Surveillance and Screening of Infants and Young Children policy statement (PEDIATRICS Vol. 108 No. 1 July 2001, pp. 192-195 or http://aappolicy.aappublications.org/cgi/content/abstract/pediatrics;108/1/192.) 5) Establish an interagency council or network to increase the number of children and youth with special health care needs who are linked to Medical Homes. 6) Conduct a community needs assessment on adolescent transition from pediatrics to adult health care and report results and recommendations to key stakeholders and policymakers.

Data Source for Measurement: SPHERE System Report to include data from the following screens: System Activity (all appropriate fields including the strategies documented in the Results/Outcome field) and Intervention: Coalition Building (no detail screen), Community Organizing (no detail screen), or Collaboration (no detail screen).

2007 MCH Program Template Objectives
Healthy Environments

Objective Statement: By December 31, 2007, **(insert number)** strategies to create environments that support and promote healthy eating, daily physical activity and a healthy weight for **(insert population focus or name of jurisdiction)** will be implemented by the **(insert name of coalition, collaborative, or partnership)**.

Deliverable: A report to include a description of the strategies implemented by the **(insert name of coalition, collaborative, or partnership)**, a description of the population focus or jurisdiction, and a description of any environmental and/or policy changes that occurred as a result of each strategy implemented.

Context: Chosen strategies must support the implementation of the Wisconsin Nutrition and Physical Activity State Plan, which provides a framework to address obesity, improve nutrition and increase physical activity. The Plan's strategies, objectives and action steps serve as a guide for all partners who are planning and implementing interventions and initiatives for the prevention and management of obesity. The strategies are primarily evidence-based or promising strategies and will impact the related health priority areas of Healthiest Wisconsin 2010: Adequate and Appropriate Nutrition; Overweight, Obesity and Lack of Physical Activity. Additionally, at-risk of overweight and overweight were identified in the recent MCH needs assessment. Strategies that may be implemented through this objective include: 1) Conduct an environmental audit to identify supports and barriers to physical activity within the community. Report results and recommendations to key stakeholders and policymakers. 2) Conduct an environmental audit to determine the number and location of outlets for fruits and vegetables within the community. Report results and recommendations to key stakeholders and policymakers. 3) Make improvements based on the community environmental audits. 4) Establish childcare, school or community gardens through the Got Dirt? Initiative. 5) Increase the number of worksites with wellness programs that include environmental and policy changes targeting the prevention and management of obesity, healthy eating and active lifestyles. 6) Assist schools in meeting the criteria for the Governor's School Health Award. 7) Continued implementation or expansion of evidence-based or promising objectives from a previous contract year.

Input Activities: Include a brief description of the strategies chosen and how they will be implemented.

Data Source for Measurement: SPHERE System Report to include data from the following screens: System Activity (all appropriate fields including the population focus or jurisdiction and strategies documented in the Results/Outcome field) and Intervention: Coalition Building (no detail screen), Community Organizing (no detail screen), Collaboration (no detail screen) and Policy Development.

2007 MCH Program Template Objectives
Home Safety Assessment

Objective Statement: By December 31, 2007, **(insert number)** residences located within **(insert name of jurisdiction)** with children ages **(insert number)** to **(insert number)** years will have a documented decrease in hazards previously identified through home safety assessments.

Deliverable: A report to document, per residence (household), the number and types of corrections made for hazards identified through home safety assessments.

Context: (Specify the staff who will provide the home safety assessment; for example, Public Health Nurse, Public Health Educator, or trained volunteer.)

Data Source for Measurement: SPHERE Individual/Household Report to include MCH Required Demographic Data and data from the following screens: Home Safety Assessment, Health Teaching Topics and Results, and Referral and Follow-Up/Results if appropriate.

For Your Information: In 2007, the SPHERE Home Safety Assessment screen can be printed if desired and used as a tool for assessing hazards in homes. The SPHERE Home Safety Assessment screen was developed by representatives from local health departments and staff within the state MCH program and is based on national as well as international research.

2007 MCH Program Template Objectives
Comprehensive School Health Program

Objective Statement: By December 31, 2007, a comprehensive plan will be developed by the **(insert name)** Health Department in partnership with **[insert name or number) school district(s)]** that addressees at least two new components found in the Wisconsin Framework for Comprehensive School Health Programs.

Deliverable: A report to include: 1) a description of the comprehensive written plan developed, 2) a description of the goals and objectives, 3) a clear delineation of agreements and contributions of the partners, and 4) a timeline that details when objectives will be achieved.

Context: The intent of this objective is to encourage a direct partnership between the local health department and their respective local school district. Schools by themselves cannot, and should not be expected to, address the nation's most serious health and social problems. Families, public health, health care workers, the media, religious organizations, community organizations that serve youth, and young people themselves also must be systematically involved. However, schools can provide a critical facility in which many agencies might work together to maintain the well being of young people. The Wisconsin Comprehensive School Health Program (CSHP) Framework http://dpi.wi.gov/sspw/chspprog1.html is composed of six components that are used to organize and implement an effective school health program. These components are: 1) healthy school environment which includes the physical, emotional, and social conditions that affect the well being of students and staff. 2) curriculum, instruction, and assessment of a planned, sequential, K-12 curriculum that addresses the physical, mental, emotional and social dimensions of health. 3) student programs designed to help address student's physical, emotional, social, and cognitive needs and help connect to school and the community. 4) adult programs designed for parents and teachers to change knowledge, attitudes, skills and practices of their children or students around a variety of health topics. 5) pupil services provided to support the healthy development of all children as well as those experiencing health and educational challenges). 6) family and community connections consisting of various formal and informal working relationships, such as networking, cooperation, coordination, and collaboration on health, prevention and youth development issues. Examples of some of the strategies that impact the Comprehensive School Health Program Model include: 1) Assist with gathering and interpreting health and education status and outcomes. 2) Develop a coordinated community plan to address chronic disease and other important health issues according to CDC school health guidelines. 3) Develop the capacity to provide education, training, and services to students, staff, and families. 4) Use technical assistance and funding to support school efforts to address education and healthy outcomes. 5) Schedule regular meetings between health and education agency leadership.

Data Source for Measurement: SPHERE System Report to include data from the following screens: System Activity (all appropriate fields including the goals and objectives and partners documented in the Results/Outcome field) and Intervention: Community Organizing, Subintervention: School Health (no detail screen) and Intervention: Policy Development, Subintervention: School Health (no detail screen).

2007 MCH Program Template Objectives

For Your Information: For technical assistance, please contact Claude Gilmore at (608) 266-9354 or via e-mail at gilmoca@dhfs.state.wi.us or Brian Weaver at (608) 266-7921 or via e-mail at brian.weaver@dpi.state.wi.us.

2007 MCH Program Template Objectives
Childhood Caries Prevention

Objective Statement: By December 31, 2007, **(insert number)** children ages 6 months to 5 years will receive early childhood caries prevention services from **(insert name)** Health Department.

Deliverable: A report to document, by child's age and type of service, the early childhood caries prevention services provided by **(insert name)** Health Department.

Context: The following early childhood oral health preventive services are integrated into primary health care visits: 1) anticipatory guidance for parents and other caregivers, 2) an oral assessment for infants and children ages 6 months through 5 years, 3) fluoride varnish applications (up to 4 applications per year per child), and 4) referral to a dentist if necessary. It is recommended that outreach be done for services to infants and young children to sites such as health clinics, WIC Program, Head Start or Early Head Start, and child care programs.

Data Source for Measurement: SPHERE Individual/Household Report to include the MCH Required Demographic Data and data from the following screens: Oral Health Assessment, Fluoride Assessment, Fluoride Varnish (no detail screen), Health Teaching (Oral Health), and Referral and Follow-Up/Results.

For Your Information: DHFS resource *Fluoride Varnish Application for Children Sample Agency Protocol*. Staff training, technical assistance and materials are available through the DHFS Oral Health Program. Contact Warren LeMay, Chief Dental Officer at (608) 266-5152 or lemaywr@dhfs.state.wi.us.

2007 MCH Program Template Objectives

Third Grade Oral Health Open Mouth Assessment/Survey

Objective Statement: By December 31, 2007, **(insert number)** third grade children will participate in an oral health survey utilizing an open mouth assessment conducted by **(insert name)** Health Department to determine the oral health status and needs of this population.

Deliverable: A report to document findings of the survey conducted by **(insert name)** Health Department utilizing an open mouth assessment of third grade children from a random sample of schools sorted by percentage of free and/or reduced price meal program participation.

Context: The oral health survey will follow the Basic Screening Survey protocol. Local health departments must collaborate with the Department of Health and Family Services Oral Health Program for survey planning, implementation and evaluation. Technical assistance includes but is not limited to selecting the sample, collecting data and survey analysis.

Data Source for Measurement: SPHERE Individual/Household Report to include the MCH Required Demographic Data and data from the following screens: Oral Health Assessment and Referral and Follow-Up/Results.

For Your Information: In 2001-2002, a statewide representative random sample of third grade children ("Make Your Smile Count Survey") was conducted by the Department of Health and Family Services (DHFS). This survey report provides a statewide and regional analysis of the oral health status of third grade children including, untreated dental caries, caries experience, dental sealant prevalence and treatment urgency. County surveys may be compared with state and regional data as a part of an oral health needs assessment. Staff training, technical assistance and material are available through the DHFS Oral Health Program. Contact Warren LeMay, Chief Dental Officer at (608) 266-5152 or lemaywr@dhfs.state.wi.us.

2007 MCH Program Template Objectives
Oral Health Assessment and Sealants

Objective Statement: By December 31, 2007, **(insert number)** children who have their first and second permanent molars and are not Medicaid eligible will receive an oral health assessment, dental sealants and referral from **(insert name)** Health Department for necessary restorative treatment needs.

Deliverable: A report to document the number of those children who have their first and second permanent molars, are not Medicaid eligible, and received oral health assessment, dental sealants and referral from **(insert name)** Health Department for necessary restorative treatment needs.

Context: School-based dental sealant programs are evidence-based prevention strategies that prevent dental caries (cavities) in the pits and fissures of permanent molars. The children targeted by this objective are usually second and sixth or seventh graders.

Data Source for Measurement: SPHERE Individual/Household Report to include the MCH Required Demographic Data and data from the following screens: Oral Health Assessment, Dental Sealants (no detail screen), and Referral and Follow-Up/Results.

For Your Information: A dentist or dental hygienist must screen, determine the need for, and place dental sealants. DHFS resource *Sealant Sample Agency Protocol*. Technical assistance is available through the DHFS Oral Health Program. Contact Warren LeMay, Chief Dental Officer at (608) 266-5152 or lemaywr@dhfs.state.wi.us.

2007 MCH Program Template Objectives
School-Based Fluoride Mouthrinse Program

Objective Statement: By December 31, 2007, **(insert number)** children ages 6 years or older from non-fluoridated communities will participate in a weekly school-based fluoride mouthrinse program administered by **(insert name)** Health Department.

Deliverable: A report to document, by age and community, the number of children who participated in a school-based fluoride mouthrinsing program administered by **(insert name)** Health Department.

Context: School-based fluoride mouthrinsing programs are evidence-based prevention strategies that prevent dental caries (cavities). The children targeted by this objective are usually first through sixth graders; however, it is also appropriate for seventh and eighth graders. School-based fluoride mouthrinsing programs are not indicated in fluoridated communities or where the natural fluoride level is at an appropriate level.

Data Source for Measurement: SPHERE Community Report to include the data from the following screens: Community Activity (all appropriate fields) and Fluoride Mouthrinse (no detail screen).

For Your Information: Technical assistance is available through the DHFS Oral Health Program. Contact Warren LeMay, Chief Dental Officer at (608) 266-5152 or lemaywr@dhfs.state.wi.us.

2007 MCH Program Template Objectives
School-Based Fluoride Supplement Program

Objective Statement: By December 31, 2007, **(insert number)** children ages 6 months through 16 years from non-fluoridated communities will participate in a dietary fluoride supplement program administered by **(insert name)** Health Department.

Deliverable: A report to document, by age and community, the number of children who participated in a dietary fluoride supplement program administered by **(insert name)** Health Department.

Context: The target population for this program is children from age 6 months to 16 years. The children targeted must not have access to fluoridated water or have natural fluoride levels at or above certain concentration levels for specific age groups. Water sources must be tested to determine the fluoride content prior to determining the dosage for dietary fluoride supplements. In other words, this program is targeted to children in non-fluoridated communities or rural areas with low natural fluoride in the water.

Data Source for Measurement: SPHERE Community Report to include the data from the following screens: Community Activity (all appropriate fields) and Fluoride Supplement (no detail screen).

For Your Information: Technical assistance is available through the DHFS Oral Health Program. Contact Warren LeMay, Chief Dental Officer at (608) 266-5152 or lemaywr@dhfs.state.wi.us.